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ABSTRACT

The problems encountered in the implementation of a behavior modification parent training program are discussed. Data was gathered at Camp Freedom, a seven-week residential behavior modification summer program for parents with retarded children. The following questions are considered in the context of training effectiveness: Which parents are most amenable to training? Which inputs are most readily utilized? Which behaviors yield most rapidly to behavior modification's advances? What are the long term effects? How can effective parent training be delivered most cheaply? Three major dimensions are identified which must receive continuing attention in the development of any group parent training program: participation, parent resistance, and development of responsibility. (CS)

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PARENTS AS TEACHERS: PROMISE AND PITFALLS

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The plight of the retarded child - inadequate teaching methods and too few people to practice them in any case - is well documented in the literature and in the awareness of every parent who has ridden the well known clinic shuttle. Hence the groundswell of interest in behavior modification parent training is surprising only in its recency.

Most programs for training parents in behavior modification reported to date have involved: (1) only one or a small group of parents, (2) considerable professional resources in the clinic or in the home, (3) highly motivated, usually middle-class parents and (4) only one troublesome target behavior, over a relatively short period of time. Not unpredictably, under these favorable conditions the literature has noted considerable success; however, these studies have served several important purposes. In helping to re-define the parents' status from that of therapeutic targets themselves to that of co-workers, they have suggested a more genuinely therapeutic involvement for families. And in demonstrating how well these parent co-workers could modify behavior they have suggested one way to begin compensating the retarded child for the otherwise inadequate methods and insufficient manpower he must endure.

Yet it is now time to pause and put these early reports in some perspective, lest professionals in the service delivery system become overly optimistic about this new approach - and overly disillusioned when their own training efforts with their own client populations fall short of the promise. The selected case examples are a faulty guide to viable community applications, with many important questions of effectiveness and cost remaining unanswered, or even unasked. Regarding effectiveness: which parents are most amenable to training? Which inputs are most readily utilized? Which behaviors yield most rapidly to behavior modification's advances? And, what are the lasting effects of it all? Regarding cost, one simple question: How can

effective parent training be delivered more cheaply?

During the past four years, a group of psychologists and special educators at Harvard University have been exploring ways to broaden the limited beginnings of behavior modification parent training. We have experimented with a variety of group formats and media supports to increase cost-effectiveness, and have involved the parents (and most recently the siblings) of over 300 retarded and disturbed children, from a wide range of family backgrounds and presenting a multitude of target problems. One focus for training has been those families with children attending our behavior modification summer program, Camp Freedom. As described in the previous paper, Camp Freedom is a seven-week residential behavior modification program serving 46 children, aged 5-13. A non-profit organization, Camp Freedom enrolls children from a wide variety of backgrounds. The families who walk through our camp gate for the first on-site training weekend might include: a mechanic and his wife, curious, if a little uneasy about returning to "school," a business executive and his wife, already facile with the catch phrases of behavior modification but suddenly awkward when called in to teach; a mother from the inner city of Boston who has made the long trip by bus to learn all she can that will help her child; a rural New Hampshire family, suspicious of agencies, with a car full of kids they couldn't find anyone to sit with; and a medical researcher and her physician husband, quite naive about child management and eager for advice from the counselor staff. These, and about five other families, will be a training group. They share in common the fact of their child's retardation and the experience of his placement in our program. Some of their initial skepticism about behavior modification has been reduced: reduced by the three required pre-camp training meetings, wherein the principles of behavior modification and the procedures of camp were described and illustrated on video tape. Reduced, too, by the very fact of their child's participation in a behavior modification camp; cognitive dissonance would have it no other way. Their weekend at camp involves observation, actual participation in teaching classes, video-taped feedback and planning of at least

one program for their follow-through immediately when the child returns home. Six or so follow-up meetings in the fall expand on behavior modification content and allow time for small group program consultation with each other and with the staff.

Such a program obviously has considerable promise, and it is very often promise fully realized; however, there are numerous pitfalls to be aware of, and I will discuss several of these next, with some reference to data gathered three years ago (Schwenn, 1971) and again last year, on samples of 27 and 38 families respectively who began the Camp Freedom training program.[1]

ENTRY PROBLEMS AND DROP OUT

Our data have indicated more sustained and continued progress post-camp in children whose parents regularly attended training and learned the principles of behavior modification well. So we want to train as many camp parents as possible.

The first discovery in developing a large-scale training program for parents, however, is that neither training nor behavior modification is for everyone. Some families welcome training, some want no part of it. Some remain in training, some drop out. Some implement programs at home, some do not. These dichotomies pose the obvious question: which families? Among the family circumstances which have been found to relate to failure to become involved in our program are the following fairly obvious ones:

1. Limited intelligence. Some families of mildly retarded children are simply not intellectually prepared to benefit from written or group instructional formats. More generally, our data suggested that families where the father's occupation demanded only limited verbal ability were more apt to drop out of training.

2. Limited support. Typically one parent in a family becomes most involved in training and carrying out teaching programs - unfortunately in most cases, the mother.

[1]Time limitations do not allow for more than a summary of findings. More complete records of results may be found in the following: Schwenn, M.R. (1971) "The effects of parent training on therapeutic behavior change in retarded children from an educational camp to home." Unpublished Honors Thesis, Harvard University. Baker, B.L. (1973) Progress report, SRS Training Grant: Training in behavior modification for retarded children. Mimeo

However, many fathers who do not regularly teach seem to play an important supportive and reinforcing role, providing the mother with an ally at meetings and being interested in programming at home.. In single parent families, however, especially those in a state of confusion and flux (e.g. father in and out, divorce imminent) participation in training is limited; our most recent data indicated the overwhelming proportion of drop outs from the program to be mothers with such limited interpersonal support at home.

3. Limited means. Our data previously found participation more limited in families with four or more children. This is obviously one correlate of poverty in general, with accessability to meetings more difficult if the family cannot obtain baby sitters, transportation and the like.

The so-called "multi-problem" family, which not only finds itself in the above circumstances but which presents the kinds of disordered behavior which these circumstances foster, is yet more difficult. Here concern for the particular child labeled retarded must compete with many equally valid concerns, and there is both little physical time and psychological space left for the painstaking efforts of, for example, toilet training or developing language skills. It is not surprising that in other parent training programs we have conducted, where enrollment was voluntary and not linked to an ongoing service for the child, these families typically did not enroll. In the camp program, they were more apt to drop out.

Limitations of intelligence, support and means can be overcome to some degree, however; we have <u>reduced</u> the relationship of these variables to family involvement (from several years ago to recently) by a number of changes in our training: (a) increased <u>accessability</u>, by conducting meetings in different locations and at different times, as well as providing transportation; (b) expanded <u>formats</u>, by relying less on lecture inputs and more on films, video tapes, role playing, demonstrations, practice teaching sessions, and small group discussions, and by becoming more flexible in the inputs

available for any given family, and (c) greater incentives, by making attendance at early meetings compulsory for the child's entering the camp program, by making home visits contingent upon group participation, and by paying families to participate. Following a procedure Hirsch and Walder (1969) found successful with middle-class mothers, our program reimburses $50 of camp tuition (which is as much as many families pay) to families missing no more than one meeting during training. Last year 73% of families attended 75% or more meetings. The main variable which discriminated high (> 75%) and low (< 75 %) attending families was only one parent at home in the latter.

Yet, attending meetings is only the beginning of involvement; the more subtle pitfalls emerge when parents must actually behave differently.

2. RESISTANCES TO CHANGING FAMILY PATTERNS

One might naively assume from successful case reports that concerned families would readily embrace a behavioral perspective as their own, and conscientiously set out to teach their child, his progress their only reward. And, then, it would come as an unhappy awakening when parents question at length the assumptions of behavior modification, or consistently seem unable to keep the simplest records, or persist in encouraging retarded behavior in the face of clear evidence that the child could do better. In fact, the entrenched practices of institutions are multiplied 10-fold in a training group of 10 families; and the predictable resistance (or at least ambivalence) toward change is expressed a bit differently in each, so the group trainer cannot as readily choose his "strategy" for dealing with a particular institutional value or practice.

Behavior modification, especially, challenges family practices; by seeing the child's behavior in its context one inevitably sees ways that other family members might help by altering their own behavior. It was our experience that the point where parents were most likely to drop out of training groups was when asked to meet some "action" demand: to begin to keep baseline data at home or to begin a program at home.

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In recent groups, we have successfully circumvented this by gradually phasing in action demands from the first session.

Two types of resistance to changing family practices vis a vis the retarded child (and these are not always distinguishable) are: a clash of values, especially regarding child rearing, and some type of gain the practices afford the family. Regarding the former, there are certainly both cultural and familial child-rearing practices which will conflict with either the general strategies of behavior modification or specific programming goals. For example, in a training program involving Rosebud Sioux education workers we encountered the traditional taboo against any form of physical punishment of children (thereby delimiting the range of acceptable approaches to disruptive behaviors) or in following up one camper we found that the entire family's value of food as the nexus for social interaction made our diet program for their 175 pound nine year old unfeasible.

Moreoften, however, a practice does not seem to reflect a strongly felt and shared value in a culture or family. With sensitivity to parents, need for support and approval in their child-rearing practices and with flexibility in programming, value conflicts typically do not present insurmountable problems.

Of more notable difficulty is when the child's retarded behavior is in some way reinforcing to the family, such that they work against odds to maintain it. The examples unfortunately, are countless. One depressed mother found one of her only expressions of competence in dressing her retarded boy, who actually learned to dress quite well by himself. Another family only paid attention to papers their daughter brought home from school when these were poor; this girl, by a previous marriage, had become for the family a convenient scapegoat. And, all too many families fear that their image of their child as incompetent and their plans for his institutionalization will be undermined if they help him to learn more skills.

So that family resistances to changing practices do not reduce our training groups to single cases, we have adopted several procedures. In essence, these entail programming for families with the same appreciation of learning principles one has in programming for a child. In selecting a target area, we usually begin with self-help skills, such as dressing, eating, grooming or housekeeping; these are most easily taught, and are the most conflict free - the desirability of learning these skills is more readily agreed upon. From initial successes we build gradually. These early programs help to develop the mutual understanding necessary for parents to venture into attempting more difficult changes, in the way they deal with their child's behavior problems, or language, or social skills. Also, it is important to shape families into producing these new behaviors. In our training, parents assume an active role from the first meeting, when they begin to complete an assessment of their child's skill levels. This first task involves relatively neutral observations, later they are asked to carry out a simple self-help skill program, next to keep data, and finally to carry out several more complex programs. On-site guidance and feedback is provided at several initial points along the way. Another useful procedure in breaking resistances is modeling - having previously trained parents discuss their programs, or encouraging the most involved members of the group to describe what they are doing. Too, putting resistant parents in the role of consultant to other parents (by breaking the group into smaller groups, setting time limits and having parents present problems to one another) is often helpful. It should finally be remembered that much resistance to behavior modification is simply fear of trying something and failing, saying something and looking foolish - in fact, the very same fears which the target children have in so much abundance. At times a gentle push is needed most.

3. PARENT RESPONSIBILITY AND AGENCY DEPENDENCY

Assume for the moment, however, that parents are regularly attending training sessions and generally in agreement with the goals and procedures for their child suggested by the training program; there still remains one enormous obstacle - perhaps greater than any of those discussed thus far. In a word: responsibility. We ultimately discover that many families believe that any real responsibility for programming for their child rests exclusively with agencies. This attitude is ubiquitous; it is found in the welfare mother who, when asked her son's age replied: "you'll have to ask my social worker," and it is found in the well-to-do families who politely endure training so that their child might return to our camp. It is found in "parent trainees" who are actually in search of a new diagnostic label, help with school placements, or simply one more group to join. The simple fact is that doing behavior modification is really quite easy, but only when parents have decided to accept this responsibility.

The agency dependency is not surprising. The medical model thrives around disturbed and retarded children; professionals talk in jargonistic phrases like "chronic encephalopathy, etiology unknown," and "confidential" reports are exchanged between clinic and school, without ever being seen by the family. A family soon comes to accept their child's problem as medical, the conceptualization as too complex for them to understand and thus, the responsibility for helping to reside elsewhere. Letting go of some of the professional mystique and involving families is difficult for many professionals. Even those who profess to train parents often manage to encourage in parents a new dependency - on them. Of course, there <u>are</u> reality demands in raising such a child - parents do need help. The challenge is to provide much needed services with the advice and involvement of families, so that they are encouraged to retain responsibility both for maintaining the quality of agency

services and also for providing adjunct home-training themselves. It has been our experience, incidentally, that as parents become better behavior modifiers at home, they also become more critical forces for better services in the community.

Training groups seem to go through at least three discernable stages; first there is skepticism, a somewhat self-conscious sizing up period which may last only a session or two. Next there is a stage of guarded cooperation and trying out the trainer's suggestions - a compliance stage, perhaps with, perhaps without a strong verbal committment to behavior modification, but lacking the initiative which comes with a real acceptance of responsibility. The third stage of genuine involvement and responsibility has more to do with assumption of a co-teacher role than with specific learnings about discriminative stimuli, extinction or partial reinforcement. Sometimes it is reached, sometimes not. But the issue of parents co-responsibility for the child's programming must be dealt with at every step if involvement is to be more than superficial and fleeting.

We have raised three dimensions to consider in developing a group parent training program; participation, resistances and responsibility. These are, of course, not the only ones, nor is attention to these more important than the creating of a solid behavior modification curriculum. But dimensions such as these must be considered if behavior modification parent training is to fulfill its very real promise.